RHODE ISLAND MEDICAL ASSISTANCE PRIOR AUTHORIZATION FORM

Recip MID(SSN) _____Last Name _____First Name _____ Middle ____ Birth Date _____

Referring Medicaid Provider Number/NPI _____Taxonomy _____

Referring Provider Name _____ Return Mailing Address _____

City _____ ST _____ ZIP _____ Phone _____ Fax _____

Performing Provider Name _____

HOSPITALS ONLY SERVICE TYPE INPATIENT ☐ OUTPATIENT ☐

DHS ONLY	BILLING PROV NUMBER/NPI	TAXONOMY	START DATE	END DATE	NDC/PROCEDURE OR REVENUE CODE/MOD	ADD MOD	TTH SRF	DIAG CODE	UNITS/ OCCUR	DOLLAR AMOUNT

(Reason service is required, diagnosis/prognosis and treatment described) _____

_____

PERFORMING PROVIDER SIGNATURE AND TITLE _____

OFFICIAL USE DO NOT WRITE BELOW

DHS AUTHORIZED _____**DHS DENIED** _____ **DATE** _____

NOTES _____

_____